Adult Patient Registration

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help!

Name_____Preferred Name_____
First MI Last

Address_____City_____State_____Zip_____

Home Phone_____ Social Security #_____

Cell Phone_____ Driver's License #_____

Email Address_____ DOB_____ Sex: M F

Employer_____Work Phone_____

Marital Status (circle one) S M W D

Spouse_____ DOB:_____Social Security #_____

Employer_____ Work Phone_____

Primary Insurance

Subscriber_____ DOB:_____Social Security #_____

Address_____ Cell Phone_____

Employer_____Dental Ins. Provider_____Work Phone_____

Secondary Insurance

Subscriber_____DOB:_____ Social Security #_____

Address_____ Cell Phone_____

Employer_____Dental Ins. Provider_____Work Phone_____

Referred By

Whom may we thank for referring you?_____

Canceled and Missed Appointments
We kindly request a 48 hour notice if you are unable to keep your reserved time with the doctor. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you. Short canceled or missed appointments are subject to a charge.

Authorization, Release and Agreement to Pay for Service Rendered
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or healthcare practitioners.

I authorize and herby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that Jackson County Dental is not enrolled in all insurance network plans. I also understand, as a courtesy, my insurance, if provided, will be filed on my behalf and that my dental insurance carrier may pay less than the actual bill for services. In the event that my insurance fails to pay in full or respond to the filed claim, I understand I am liable for the existing balance.

I agree to be responsible for payment of all services rendered on my behalf of my dependents. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide addition dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs incurred in attempting to collect on this amount or any future outstanding account balances, including but not limited to fees charged by an outside collection service, court cost, and reasonable attorney fees.

Financial Arrangement
For your convenience, we offer the following methods of payment: **cash, personal check, debit and credit cards- Visa, Mastercard and Discover and Care Credit.**

_____ _____

Signature Date